BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Eligibility of: BRIAN S., Claimant, vs. SAN ANDREAS REGIONAL CENTER, Service Agency.	OAH No. N 2005110253

DECISION

Administrative Law Judge M. Amanda Behe, Office of Administrative Hearings, State of California, heard this state level fair hearing in Oakland, California, on August 28, 29, 30, and 31, and September 7, 2006

Claimant was represented by Louise Katz, Attorney at Law. Claimant was not present at hearing and did not testify. Claimant's mother, Susan S., was present and testified.

San Andreas Regional Center, the service agency, was represented by Nancy Johnson, Attorney at Law.

The matter was electronically recorded and the evidentiary record closed on September 7, 2006. Claimant's brief was received as Exhibit DDD. SARC's brief was received as Exhibit 35.

ISSUES IN DISPUTE

1. Is claimant eligible for regional center services on the basis of Autism?

2. Is claimant eligible for regional center services on the basis of a disabling condition closely related to mental retardation or requiring treatment similar to that required for people with mental retardation?

FACTUAL FINDINGS

1. Claimant Brian S. was born on August 14, 1979, and is 27 years of age.

2. On November 7, 2005, claimant personally completed a Fair Hearing Request in which he requested a hearing because he disagreed with SARC's decision that he was not eligible for regional center services. He wrote on the form that the desired outcome was "to qualify for services." The Fair Hearing Request was timely and proper, and received by SARC on November 7, 2005.

3. In approximately May-June 2005 claimant's mother called SARC requesting to apply for on-going case management, Independent Living Skills training, social skills training, job training and placement services, and money management services.

The mother completed a SARC Application for Determination of Eligibility Due to a Developmental Disability on which she asserted that claimant was eligible for services under the conditions of Autism and Other Condition needing services similar to the mentally retarded.

4. Jennifer Hayes-Luong[1], a SARC Intake Counselor, and Susan Heimlich, Ph.D.[2], conducted an Intake Interview with claimant and his mother. Dr. Heimlich recalled that they were told that claimant had been diagnosed with Asperger's Disorder, and she reviewed the categories that did and did not qualify an individual for regional center services. Claimant appeared to understand what the categories were, and expressed that he did not want to associate in any way with people who were retarded and considered that he was not retarded. He was angry and did not want to be present at the intake interview. Dr. Heimlich was glad he stayed to end and provided consent for SARC to obtain additional information.

Dr. Heimlich and Ms. Hayes-Luong posed questions about the pregnancy, labor, birth, developmental milestones, when parents first started having concerns, etc. Ms. Hayes-Luong noted that the mother had left some sections incomplete or blank on the SARC

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[1] Ms. Hayes-Luong has a bachelor's degree in child development, and worked for the Children's Health Council as an aide for an autistic child, and later at a home for moderately disabled children. She was an Independent Living Skills instructor at Community Options, and then a case manager at Social Vocational Services. She had worked at SARC for five years.

[2] Dr. Heimlich is SARC's clinical licensed psychologist in intake. At SARC since February 2002. evaluates materials that are brought to us, participate in decision regarding eligibility, quality assurance reviews of homes and day care facilities. Intake and eligibility determinations is almost all of her 4/5 time position. 100-120 intakes each year. Exhibit 1. Dr. Heimlich is licensed as a clinical psychologist in New York State and California. In 1975 she received her doctorate from the University of Illinois. From 1979 to 1981 Dr. Heimlich was Residential Director of St. Christopher's Home, a residential treatment center for children too disturbed or developmentally disabled for foster care. She next worked for the Bronx Developmental Disabilities Services Office as, sequentially, a psychologist, coordinator of resource development, and director of program development, principal psychologist, and coordinator of River Avenue Day Treatment Program. In the latter position she oversaw a program with an inder-disciplinary staff of over 22. From 1990 to 2001 she was psychologist for New York State, providing services to developmentally disabled individuals in institutions and group homes, with responsibility for advocacy, assessment, creation and monitoring of behavior intervention programs, and serving on eligibility teams. Dr. Heimlich described that the majority of her Continuing Education has been in autism, diagnosis, differential diagnosis, etc.

Application for Determination of Eligibility Due to a Developmental Disability and asked questions about those subjects to complete the form. She annotated the form with additional information, including some lengthy entries, in eight areas.

During the intake interview Ms. Hayes-Luong asked questions and recorded answers on the CDER Evaluation Element, which covered Motor Domain, Independent Living Domain, Social Domain, Emotional Domain, Cognitive Domain, and Communication Domain. Ms. Hayes-Luong wrote various comments by the mother and claimant on the form, as well as checking the appropriate level for each question. Claimant discussed work that he had an internship with Tower Record while in high school, but it did not pan out, and he did not do any other jobs because after graduation he just curled up in a ball and wanted to hide.

The mother talked about Asperger's Disorder, and Dr. Heimlich asked claimant how he felt about it. He said he got drunk and high, but quit drugs after high school. He commented that you are either happy or you're not, and no drugs are going to make you happy. In the meeting Ms. Hayes-Luong was worried that claimant was angry and might physically express his anger, so she smiled a lot, commented on his necklace and hair, etc. to keep him mellow. She observed that the mother was doing a great job redirecting him and keeping him in a good mood, and he was calmer at end of meeting.

At hearing the mother criticized the intake interview, including that questions were not directed specifically to claimant or her but were answered by both. She also testified that she believes Ms. Hayes-Luong's entries on the form were from the application because the text of the form was not read aloud during the interview. Her view was not persuasive. Review of the document indicates that reading aloud the four, five or six descriptions of the range of responses would not be necessary to appropriate completion of the form. Moreover, the mother's own description of the completion was contradictory. She complained that Ms. Hayes-Luong did not ask follow-up questions, but also described that after posing a general question at first Ms. Hayes-Luong would ask more specific questions, such as if claimant had to buy an item costing $4 what currency would he need. The evidence, including the notations on the form, indicated that Ms. Hayes-Luong sought the data required by the evaluation tool, and noted it on the form.

5. The mother provided documents related to claimant's application at the interview and Ms. Hayes-Luong sent off releases signed by claimant to obtain school and other records. Ms. Hayes-Luong's five-page Intake Social Assessment included information from the intake interview and the records. The assessment was organized in categories including family situation, developmental history, and current functioning.

Claimant, aged 25, was an unconserved adult who had been living with the mother since November 2004. The mother related that claimant held up his head at 3-4 months, sat alone at 6 months, crawled at 8 months, stood at 1 year, walked at 1 year, spoke his first words at 10-16 months, spoke in phrases at 18 months, fed himself at 2 years, was toilet trained at 4 years, and dressed himself at 7-8 years.

At age five claimant was hospitalized in traction for a fractured femur. He seized and was resuscitated. The neurological pediatric specialist revived his EEG and determined he did not have epilepsy. The mother recalled the consensus was that the event was a reaction to Demerol.

The mother related that she was first concerned about claimant's development when he was one or two years old. He had limited socialization, not really aware of his surroundings, seemed able to formulate words but then would not use them, was sensitive to noise, and was slow to master some skills.

With regard to current functioning, claimant reported that he has no problems with fine or gross motor skills. Although his mother reported that he does not express himself well claimant displayed a broad vocabulary, and understanding of appropriate use, and his speech was easily understood. His mother stated that she feels he does not understand the point of view of others, or how things affect others, and that he lacks a variety of facial expressions for expressive nonverbal communication and has limited receptive nonverbal communication. His receptive language skills allow him to understand complex conversations and the meanings of story plots, and he was reported to enjoy reading novels.

In the social/emotional domain both claimant and his mother provided information and examples to Ms. Hayes-Luong. Claimant was verbally abusing and threatening to others, but during the preceding year he had not caused physical injury but had caused minor property damage a few times. He was impatient, and reportedly misread others' body language and became angry often. On a weekly basis he became aggressive or obstructive when hindered or obstructed, and displayed a temper tantrum. When upset in the car he would unlatch his seatbelt and open the door of the moving car. Claimant stated "Lots of crap has made me into an angry little person – I don't have a constructive outlet." Both reported that depressive-like behavior inhibited his functions. Repetitive body movements occurred only when under stress, and were limited to finger tapping. He reportedly tried to hang himself five times. He was upset by changes in social relationships and physical environment.

In the cognitive domain, claimant was reported to be able to read and understand complex sentences and stores, write in longhand and print, and add and subtract but with difficulty for numbers larger than 10. In high school he successfully assisted other students having difficult with reading, and found ways to explain words and phrases with which they were having trouble. He was reportedly very kind and caring. His attention span was reported as 30+ minutes, but he had difficulty remembering instructions and needed repetition and prompts.

In the domain of independent living and self-help skills claimant was able to prepare simple foods in the microwave, make his bed, wash dishes although he does one dish at a time, handle person hygiene, dress, use public transportation with training, perform simple first aid, order meals, and take medications with prompts. He was reported to be able to

make purchases, use and ATM, and write out checks, but needs help with budgeting. He enjoys free time alone listening to music, playing video games, watching television, and occasionally e-mailing a friend in Seattle.

In the vocational domain claimant reported that he has not received vocational training.

In the health/medical domain neither claimant nor his mother could remember the date of his last physical, and he did not take any medications or have a doctor or dentist. The November 30, 1996 diagnosis by Charles Huffine, M.D., of Asperger's Disorder Pervasive Developmental Delay was reported[3]. Claimant has historically taken Paxil, Mellaril, Olanzepine, Valporic Acid, Depakote, Lithium, Trilafon, and Ritalin

In the educational domain claimant had graduated from high school, and qualified for special education reportedly as "Health Impaired." A December 9, 1996, Shoreline Public School Special Education report noted he as in "special programs, both public and institutional for serious emotional disturbance and behavioral disability, since elementary school."

At the time of intake claimant was living with his mother but expressed an interest in living on his own someday. He was receiving $609 SSI monthly and was his own payee, although the mother stated it may revert to her. He has MediCal benefits.

6. On September 28, 2005, Dr. Heimlich completed a Psychological Summary which considered the information provided in the intake interview, reports submitted in support of claimant's application and the parameters of eligibility for regional center services.

From claimant's participation in the intake interview Dr. Heimlich considered that he followed and participated in the conversation, knew what was going on, spoke well when he choose to, and regarded himself as not mentally retarded. He was clearly not interested in being there, having a hard time with the situation, appeared that he could be physically aggressive. He had social skill problems as demonstrated by saying off-putting things. He was sufficiently self-aware to describe a life and past that was socially uncomfortable, and although desiring friends he did not know how to make and keep them. From the information reported by both claimant and the mother, and her observations, Dr. Heimlich's main impression was that he had emotional disturbance issues.

The documentation provided concerning claimant's early years, school records including psychological testing and IQ testing, the report of his psychologist from high

[3] The report that Dr. Huffine diagnosed Pervasive Developmental Delay was false; his report stated only Asperger's Disorder.

school years, and recent information all fit Dr. Huffine's diagnosis of Asperger's Disorder. In consequence, Dr. Heimlich determined that further psychological testing was unnecessary.

In school on the Wechsler Intelligence Scale for Children- Revised claimant obtained a Verbal IQ score of 119, a Performance IQ of 101, and a Full Scale IQ of 112, which are in the average range of intellectual abilities with his verbal skills exceeding nonverbal skills. On the Vineland Adaptive Behavior Scales he obtained results of:

Domain	Age Equivalent
Communication	6 years 10 months
Daily Living Skills	5 years 5 months
Socialization	4 years 9 months

Dr. Heimlich noted that school records reflected that as the result of test results claimant was transferred to a half-day kindergarten where he made progress in peer relationships, and made eligible for special education due to Health Impairment due to some motoric clumsiness. Physical therapy was recommended as well as counseling to assist with social skills.

At age eight claimant had been diagnosed with Attention Deficit Disorder, with an extremely positive response to Ritalin, and he was again assessed. In September 1987 on the WISC-R he obtained a Verbal IQ of 96, a Performance IQ of 90, and a Full Scale IQ of 92. On the Vineland his Adaptive Behavior Composite was 93, with all areas rated as adequate by the mother. His math skills lagged behind spelling, but his reading was advanced for his age. In 1988 he was in regular education classes for 1500 minutes per week with 150 minutes of resource room support for math and behavior. In June 1993, a therapist at the Good Samaritan School day treatment program wrote that claimant had a learning disability in math, very low tolerance for frustration, fears and anxieties, misperceptions of others' intention, depression and grief about familial losses. He described claimant's behaviors of sitting with his head down and hat over his eyes, although that conduct had improved, and his self-isolation when stressed and showing verbal aggression.

In 1993, after claimant had moved to Santa Clara County, a psychological report showed he tested with average intelligence. He was in the eighth grade at Campbell Middle School, and an eligibility summary noted serious emotional disturbance. He and the mother signed the form which noted characteristics of in inability to learn not explained by intellectual, sensory or health factors except ADD; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings; and a general pervasive mood of unhappiness or depression. The same document contained preprinted criteria of autism; none of those characteristics were check.

Claimant had stopped taking Ritalin about age seven. The records reviewed by Dr. Heimlich noted he had a trial on Lithium from 1993-94 but that was discontinued. A May 1995 school summary noted that claimant met the criteria for services as someone who was severely behaviorally disturbed.

Dr. Heimlich reviewed another evaluation of claimant competed in September 1996, when he had returned to Seattle and was attending Shorecrest High School at age 17. Claimant again scored above average in reading, average in written language, and quite poorly in math skills. The school psychologist noted his diagnosis had recently changed from emotional disturbance to Asperger's Disorder. Dr. Heimlich noted the number of consistent evaluations of claimant's intelligence, and opined that there was no reason after age 18 to again test his intelligence.

Dr. Heimlich reviewed Dr. Huffine's reports beginning with the intake evaluation on March 27, 1996, which contained his contacts with other involved professionals and claimant's father. Dr. Huffine ruled out a number of psychiatric disorders and concluded that he had Asperger's Syndrome, noting his grossly impaired peer relationships, lack of spontaneous sharing, and lack of social and emotional reciprocity. Dr. Huffine eliminated a diagnosis of Autistic Disorder, pointing out that there were no significant impairments intellectually or in language. She also reviewed a January 2005 Community Psychiatric Clinic report diagnosing claimant with Major Depression (296.33) in addition to Asperger's Disorder (299.80), and noting frequent periods of depression, thoughts of death and suicide, and lack of interest.

Dr. Heimlich's Psychological Summary concluded with the following Impression:

> Dr. Huffine has made a strong case that [claimant] has Asperger's Disorder, which is on the Pervasive Developmental Disorder spectrum but is not the same thing as Autistic Disorder. Whereas Autistic Disorder is served by the Regional Center system, Asperger's Disorder is not. In fact, Dr. Huffine has called [claimant] someone having 'a serious and chronic mental health problem.' To reiterate, SARC serves people with mental retardation, autism, cerebral palsy, or epilepsy or people functioning like those with mental retardation and requiring the same services. These conditions must lead to substantial handicaps in adaptive functioning and must be life-long. SARC is precluded from serving individuals whose difficulties stem from physical impairment, a learning disability or an emotional disturbance. [Claimant] needs services not like someone with mental retardation but rather like someone with emotional disturbance. He is not eligible for services from SARC.

7. On October 6, 2005, claimant, the mother, Dr. Heimlich and Ms. Hayes-Luong assembled for a meeting at SARC. Dr. Heimlich went through conditions that do not make an individual eligible for regional center services, and specifically discussed the wide autism spectrum and mental retardation/other. Claimant very adamantly expressed that he was not mentally retarded, and has nothing wrong at all. Dr. Heimlich stated he did not have autism and was not eligible for services. Claimant become very upset, jumped up and said now he

would have to fill out more paperwork at other agencies and would have to do these things on his own. Claimant also said he had been rejected again and why the fuck did SARC waste his time.

The mother stated she was totally surprised that claimant was ineligible, and that a community provider had told her that he would be accepted. Dr. Heimlich stated that the basis for the decision would be reiterated in her Denial Letter, and that he had a right to a fair hearing.

Dr. Heimlich asked him about his interest in employment and he asked why she wanted to know. She replied that she could advise them of other resources in the community. Claimant walked out of the meeting and Ms. Hayes-Luong followed to calm him down and make sure he stayed in the area. She initiated talking about music and asked what would be good music to introduce her daughter to basic rock. Claimant asked about how old her daughter was and what groups she liked, and they continued to converse.

On October 11, 2005, Dr. Heimlich wrote to claimant that based on the records provided he was clearly not mentally retarded or even close to mentally retarded, and had Asperger's Disorder rather than Autism. She wrote that because SARC serves only Autistic Disorder, and not any of the other pervasive developmental disorders, he was ineligible for services. Dr. Heimlich included a paper describing the relevant regulations, and noted that he could file a fair hearing request. She listed various community resources and internet resources that could be of assistance to claimant in areas of housing, employment, transportation, and social opportunities.

8. After the determination of ineligibility the mother hired an attorney, Ms. Katz, and they secured the services of Corrina Grandison, Ph.D.[4], for an assessment of claimant. Ms. Katz and claimant's mother discussed eligibility for regional center services with Dr. Grandison. Dr. Grandison already knew that a diagnosis of Asperger's would mean claimant was not eligible but with a diagnosis of autism he might be.

Dr. Grandison's undated report noted that she interviewed the mother for two hours on March 11, 2006, and claimant for two hours on April 1, 2006. She wrote that the assessment was sought "as he was rejected for Regional Center services last summer." Dr. Grandison reviewed mental health and educational reports and records, and testing conducted by Dr. Gordon Ulrey in March 2005. She spoke by telephone with Dr. Huffine and Betty Esmay, claimant's daycare provider from ages one to three.

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[4] Dr. Grandison obtained her Ph.D. at Boston University, and completed her clinical training at Boston Children's Hospital. She held a staff appointment at Harvard Medical School, and worked in the Department of Psychiatry at Massachusetts General Hospital. She was the staff neuropsychologist in the UCSF Infant-Parent Program for five years, and her duties included training and teaching early infant development. Since 2000 Dr. Grandison has been the Director of Assessment Services as Children's Hospital in Oakland, performing assessments and providing training for post-doctoral fellows in neuropsychology. She sees about seven clients per month in her private practice.

The hearsay statement of Ms. Esmay was that claimant was "different" and preferred to stay by himself. The mother provided responses for the Adaptive Behavior Assessment System II; based on her information claimant was rated in the deficient range.

The mother advised that claimant was putting words together about 18 months. Dr. Grandison's report stated that:

> While onset [of language] was not delayed per se, he was communicative to a limited degree. He did not ask many questions and did not express his wishes much. He used very few gestures and did not offer much feedback or reciprocity. He did not seek out peers to play with and preferred to keep to himself. In his play, he enjoyed moving parts and manipulating pieces rather than setting up imaginative scenarios. He engaged in repetitive activities such as pulling out records from a pile one at a time, touch them in a certain way, stack them up precisely in a pile, or drum excessively. He was very prone to routine and engaged in robotic behaviors. Mental inflexibility was observed early on.

Dr. Grandison also reported that:

> In March 2005 [claimant] was seen by Dr. Ulrey, Clinical Neuropsychologist. Review of test data supplied by him reveals an overall average IQ (Full Scale 91 on WAIS III) but significant discrepancies: Processing speed was extremely low (index 73) and Working Memory was low as well (index 80). Academic testing shows weak math ability (Applied Problems 68 on WJ III). [Claimant] shows significant impairment on a test of mental flexibility (only 3 of 6 categories achieved on Wisconsin Card Sorting Test, with 135 perseverative responses).

Dr. Grandison noted claimant's long mental health history, that he was diagnosed with ADHD early on, and that at age 17 he was diagnosed with Asperger's Syndrome by Dr. Huffine[5], who "ruled out Autistic Disorder based on normal language." Dr. Grandison's report included the following:

> A careful review of diagnostic criteria for Autistic Disorder versus Asperger's Syndrome as they pertain to [claimant] are as follows:
>
> 1. Qualitative impairment in social interaction as manifest by:

[5] Dr. Grandison reported that Dr. Huffine was a psychologist; in fact he is a psychiatrist.

a. Marked impairment in the use of multiple non-verbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction: This applies in [claimant's] case both at the present time as well as throughout his childhood. His affective expressions are flat and his gestural communication is significantly reduced.

b. Failure to develop peer relationships appropriate to developmental level: This is clearly the case in [claimant's] life. He has no active friendships, although he talks about a person in Seattle with whom he has some sporadic phone contact.

c, d. Lack of spontaneous seeking to share enjoyment and lack of social-emotional reciprocity: This applies in [claimant's] case as he does not share positive affects or emotional reciprocity. He has limited empathic ability and the quality of his hugs is described as 'robotic.'

2. Qualitative impairment in communication as manifest by:

a. Delay in or total lack of development of spoken language: This does not apply to [claimant] who clearly is verbally able to use language.

b. In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others: This applies in [claimant's] case, already as a toddler he was noted to use language to a limited degree for the purpose of social interaction or self-expression.

c. Stereotyped and repetitive use of language: This does not apply in [claimant's] case.

d. Lack of varied spontaneous make-believe play or social imitative play appropriate to developmental level. This applies in [claimant's] case. As a young child, he was stacking and constructing, but not engaging in make-believe or social play.

3. Restricted, repetitive, and stereotyped patters of behavior, interests, and activities:

   a. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest: This applies to [claimant] who has shown little curiosity and exploratory activities. His interests are significantly limited.

   b. Inflexible adherence to routines: [Claimant] performs certain actions extremely slowly and pedantically.

   c. Stereotyped or repetitive motor mannerisms: This does not apply in [claimant's] case.

   d. Persistent preoccupation with parts of objects: This does not apply in [claimant's] case.

A review of the diagnostic criteria for autism revealed that [claimant] indeed meets the criteria for this disorder. The DSM-IV compares Autistic Disorder with Asperger's Disorder by stating 'In Asperger's Disorder there are no clinically significant delays in language (single words are used by two years, communicative phrases are used by three years).' While [claimant] started to use language at the expected rate, his social use of language was and continues to be atypical. Hence he meets criteria for Autism, above and beyond Asperger's.

Dr. Grandison testified that children on "the autism spectrum" engage in the robotic handing of objects which the mother described. Dr. Grandison considered it significant that the mother, Ms. Esmay, and the school records reflect that claimant did not seek out the company of others.

Dr. Grandison testified that claimant had never been assessed for autism, although he had been described as a child not making friends. She also stated that she put emphasis on autistic disorder because Dr. Huffine did not take a thorough look at claimant's first few years, and she wanted to do a thorough analysis of first years of use of language. In fact, Dr. Huffine's report reflected that he considered and ruled out the diagnosis of autism, and he recorded and considered information from both parents and the schools regarding use of language. The school records of claimant's qualifications for special education were preprinted with various qualifying diagnoses including autism; that the "boxes" for autism were not check does not establish that the condition was not considered but rather that it was not demonstrated.

Dr. Grandison testified that she concluded that what Dr. Huffine and the schools described at the time as behavior problems were the result of claimant's significant communication handicaps evident from first part of his life. The examples she gave, such as her view that claimant not following teachers' directions could be the result of communication problems "rather than oppositional behavior" was clearly guessing in hindsight.

Although the lengthy reports of Dr. Huffine [quoted below] reflect extended conversations with claimant, and his clear and unequivocal statements of his views, Dr. Grandison opined that even with big vocabularies children with autism may not be able to express themselves well. Her views that claimant was unable to express himself were not supported by the evidence.

Dr. Grandison opined that documents from Dr. Ulrey indicate claimant has an average to low-average IQ. She opined that claimant's apparent decline in verbal skills when tested by Dr. Ulrey, in comparison to scores when at school, was not diagnostic but was interesting. Dr. Grandison noted that IQ testing of adults deals with more abstract concepts. She further opined that verbal IQ does not give an indication of communication skills, because verbal skills can be anything from a fund of knowledge, synthesizing information, etc. Claimant's performance on the Wisconsin Card-sorting Test, a measure of mental flexibility requiring incorporation of feedback and responsive shifts in strategy, indicated significant impairment in everyday adaptability and tasks. Those results related to his reported perseverative behaviors, such as washing one dish at a time. She acknowledged that an average to low-average IQ is distinct from mental retardation.

Dr. Grandison was clearly sympathetic to claimant's frustration with life, as demonstrated by her testimony that he does not know how to act in the world for good mental health and because he "is also on the bright side, so he understands that the world is out there and sees that he is not fitting into it." She expressed that she is very concerned about his ability to obtain a job with his challenged adaptive, social and communication skills and that he needs a lot of structured teaching in how to handle tasks, such as independent living skills and social skills.

Dr. Grandison acknowledged that the distinction drawn in the Diagnostic and Statistical Manual of Mental Disorders, Text Revision[6] (DSM-IV-TR) between autism and Asperger's Disorder is early social communication delay, a qualitative delays in communication with onset before age three. She further admitted on cross-examination that a diagnosis of Asperger's Disorder is supposed to rule out other diagnoses, and claimant had no clinically significant delay in cognitive development.

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[6] The current Diagnostic Statistical Manual, Fourth Edition, Text Revised, was published in 2000 by the American Psychiatric Association.

Dr. Grandison contacted Charles Huffine, M.D., a psychiatrist who had treated claimant for five years, and discussed his case and that he had been found ineligible for SARC services.

9. Dr. Huffine has been a psychiatrist to children and adolescents since 1995 in Seattle. Dr. Huffine recalled that Dr. Grandison called and stated she was reevaluating claimant. Dr. Huffine testified that he "was eager to collaborate with her and share my information and experience." He remembered that in their conversations Dr. Grandison pointed out information on language development in relation to autism, and that she had had a thorough conversation with claimant's mother about his development.

Dr. Huffine was claimant's treating psychiatrist from 1996 until November 2000. In 1996 claimant was 17 years old and living with his father. He initially presented as an angry, surly teenager, but was extremely anxious when confronted in any way. Dr. Huffine reviewed various records and reports, and spoke to claimant's mother and school staff. Claimant's father reported that claimant had experienced no language delays as a toddler. Claimant had grave difficulties affecting academic performance including not doing homework, but could do well in academic skills of math and reading when motivated.

Between May 16 and November 30, 1996, Dr. Huffine saw claimant in 24 hour-long sessions, with claimant's father joining them for the last 30 minutes of each session. On November 30, 1996, Dr. Huffine wrote to Greenspring, the father's managed care insurer, a four-page report of his observations, analysis and diagnoses. Dr. Huffine reported that:

> In my initial hours with [claimant] he presented as a thoroughly miserable boy who felt 'screwed by everyone.' He blasted his father, who he felt would eventually abandon him, and his mother who he raged at for her rejection of him, for abandoning him and for her Lesbian orientation. He claimed he had no friends, school was terrible, teachers all cruel and he held special contempt for all mental health workers. At various points in these first hours he would soften on a particular person or group and could engage in some thoughtful dialogue about himself with respect to others. He presented as an overweight boy, poorly groomed, with grossly inappropriate habits of picking his nose or scratching himself. He would appear to be oblivious of his behaviors initially but when (sic) got a hint of their being offensive the behavior escalated dramatically. He was prone to repeated physical complaints and often appeared tired. He frequently tried to go to sleep in sessions. His father noted that he is rarely before of (sic) after sessions. At other times he was up and about the office, picking up objects and commenting on activities out the windows. His conversation was disjointed, inconsistent and had constant paranoid trends in the content. At times he became obsessed with a problem and

was extremely agitated, anxious and illogical. He would either not respond to my interventions by ignoring me or he would tangle with me as I tried to communicate with him, even when I attempted to be reassuring. At several points he walked out of my office angrily and twice threatened me with physical harm. Rarely did he join with me in a truly two way dialogue. At the end of the evaluation period when deciding whether to continue he declared a wish to continue with me and noted that I was the only mental health profession with whom he could relate.

During this period [claimant] did have some legitimate medical problems. Dr. Flemming had attempted to treat him with a trial of Lithium. He had severe gastrointestinal symptoms, was worked up for possible PUD, but with a change to Valproic Acid his symptoms cleared. Dr. Flemming had also had him on Paxil during this period and had experimented briefly with low doses of Mellaril which seemed to add little. His father noted that the addition of mood stabilizers had softened his behavior at home dramatically. Before I became involved, [claimant's] behavior had escalated into physical confrontations with his father requiring police involvement on at least one occasion. He was settling into a routine with his father where they began to have civil discussions and were able to make plans together. [The father] could extract from [claimant] the basic necessities of cooperation so they could share their home. [Claimant] also seemed to do better at school and began to attend a church group where he found some acceptance by the staff and tolerance from his peers. He has an age appropriate but nevertheless comprehensive and obsessive interest in rock music. Despite provocative talk occasionally about drugs there is no evidence that [claimant] has indulged in any drug use other then (sic) the most minor experimentation.

In my review of his history with [the father], and recently with [the mother] of Sunnyvale, CA, I learned that [claimant] had been a difficult child from the beginning. As baby (sic) he was irritable. As a toddler he was unusually fussy, not easily relatable and prone to sitting for long periods enjoying repetitive play. He had no significant delays in language development or in the development of self help skills. He did not adjust well to school or to peers. He could relate to children much younger but never to peers. He seemed extremely anxious and fearful. He was in some form of special education from the beginning. He was seen at Group Health in Seattle and was treated for several years at Good Samaritan in Puyallup. His parents had

difficulties in their marriage. [The father] fought frequently with [claimant's] mother. These problems interfered with his having a consistent relationship with his son in these early years. When [the mother] left the marriage she and [claimant] moved to California where he entered a mental health day treatment program and school. She reports that he did well in that program. Other then (sic) a psychological testing report from Group Health, dated May 1993, I have no formal reports from any of the prior treatment programs and do not know what diagnostic assumptions were made about him in these earlier evaluations. The psychological testing measured [claimant's] performance intellectually in the low normal range but they noted he was uncooperative with the testing. [Claimant] eventually had such severe behavior problems while living with his mother that his care was transferred to his father back in the Seattle area a year before I began with them.

. . .

Much of my involvement since early May has been for the purpose of an extended evaluation. [Claimant's] diagnostic picture was initially not clear either to me or Dr. Flemming. His parents feel that his condition was never well understood by earlier examiners and therapists. My initial observations were that [claimant] suffered from severe anxiety which he covered with a thin veneer of surly adolescent hostility. He declared himself chronically depressed but despite his morbidly hostile affect and constant complaints he did not have the full diagnostic picture of depression. I considered that his being treated with mood stabilizers and Paxil for a significant time may have affected his symptoms. His father reported that with the addition of mood stabilizers there was a dramatic reduction in his level of agitation and anxiety. Nevertheless none of his earlier behaviors fit clearly the diagnostic criteria for Bipolar Affective Disorder I or II or for any other mood disorder. He has periods of depressed mood in which he is agitated and morbidly preoccupied with being miserable, but this does not remain his predominant mood for sufficient time to qualify as a depressive episode. His agitated behavior, provocativeness and general irritability with some grandiosity and paranoid ideation do not alone qualify as mania. He does not have signs of manic loquaciousness, expansiveness, racing thoughts, distractibility, decreased need for sleep, hyperactivity or behavior which reflects abandoned inhibitions with bad judgment. Nevertheless he has improved with a mood stabilizer. [Claimant's] thinking reflects a psychotic level of disconnection with the realities of his environment and a psychotic level sensitivity (sic) in his

relations to others. Most relationships are terrifying and disappointing to him but he can tolerate some closeness with his parents and in more highly structured peer settings. He certainly does not meet the criteria for Schizophrenic Disorders at this point in his life in part because he is not old enough to have accumulated the history typical of such a chronic condition. Interestingly [claimant] relates very well with younger children. He has been given a role by his school in assisting a teacher with younger kids.

My current thinking, having again reviewed his early history, is that [claimant] has had a pervasive developmental disorder throughout his life. He meets criteria for all items of 299.80 Asperger's Disorder's cluster A, social impairments. He has marked impairments in his non-verbal social interactions as demonstrated by his gross behaviors for which he is either oblivious or provocative. He has grossly impaired peer relationships and he does not spontaneously share things he is enjoying. I have noted in session that he prefers to keep his games and magazines to himself when I ask him to share that he has brought into the office. He demonstrates a marked lack of social and emotional reciprocity except for certain special times with his father, or in more structured situations such as his church group. For cluster B, he has one encompassing preoccupation: rock music. This is not dysfunctional and may be his one route into some form of age appropriate peer relating, but it is obsessional and restricted and his interest is unusually intense even for a teenager. His behavior certainly meets the qualifier for causing clinically significant impairment in social, occupational (educational) and other areas of functioning. These impairments exist despite his not having significant impairments intellectually or in language. While he could qualify for a second diagnosis of anxiety disorder, I believe those symptoms should be considered as subsumed in the primary diagnosis of Asperger's Disorder. While there is no set pharmacological approach to Asperger's Disorder it is not unusual that an individual person with the condition may respond idiosyncratically to any psychotropic medication. The mood disorder medications are targeted at his agitation which is part of his illness and empirically we find that it is helpful.

As the profundity of this boys (sic) psychopathology emerged in my original evaluation I shifted from attempting to establish a relationship basis for individual psychotherapy to initiating a more psychosocial rehabilitation model of care. My goals for

> treatment since early May have been to; 1) establish a format and a pattern for teaching social skills, 2) problem solve with [claimant] his social and functional difficulties, 3) provide psychoeducation and 4) support transitions to care systems and activities which will serve him as he becomes an adult. I am using brief individual sessions weekly to promote social skills acquisition and to deal with practical problem solving. I have reinforced this individual effort by including the father halfway in the session and transferring the momentum of our discussion to [claimant] and his father. The pace of social skills and problem solving improvement is slow and faltering. I am committed to this process and understand that this is a long term project. . . .

Dr. Huffine testified that Asperger's Disorder was a new diagnosis that had just been published in the DSM-IV-TR, and it seemed to fill a niche with the key discrimination of absence of language delays.

10. On January 17, 1988, Dr. Huffine wrote a four-page report of his observations, analysis and diagnoses to the State of Washington Department of Social and Health Services to support claimant's application for Supplemental Security Insurance. Dr. Huffine reported that he had been seeing claimant for 58 sessions over a two-year period, and that claimant was "invariably angry," "sticks with paranoid ideas regarding others with a great deal of tenacity and repetition and often with increasing anger," and "has spit on my floor and threatened assault." Dr. Huffine described that claimant assaulted his father during one session, and police were called to escort him from another.

Dr. Huffine reported that claimant used video games and computers, and had "an encyclopedic knowledge of current rock musicians and bands and seems to spend a great deal of time listening to music or reading about it." Claimant is living with his father, who described many positive interactions, but they also had severe fights and on one occasion the father called the police. On another occasion claimant set fire to items in the father's bedroom. Claimant visited his mother who continued to live in California.

Dr. Huffine reported claimant's academic status as follows:

> At school [claimant] has done little academic work since beginning in the Shoreline School district at age 15. He attended Shorecrest School for the past two years placed in a program for behaviorally disturbed students. He has refused to do homework and pays little attention in class. He has had serious peer problems at school. He insults and provokes other students and is easily provoked by tough teenagers who see him as an easy victim. His veneer is as a tough kid, but he has no experience fighting and in fact is terrified of tough peers. He

> has offended school rules and has been the subject of numerous conferences as to his educational disposition. He was recently transferred to a more structured special education program at Shorewood High School. He is unlike any other student in that school system and did not fit at all well into the new program. He is now in a class by himself with no planned curriculum and with the school at a loss as to what to offer him. [Claimant] hates his 'solitary confinement' but is relieved to be away from the offending peers in his class.

Dr. Huffine recounted that claimant was evaluated at age five by Group Health's mental health program, and psychological testing revealed that he was above average in intelligence. He played by himself at home for hours, often in repetitive routines. His parents were preoccupied with their own problems, with the mother going to law school and the father working long hours as a programmer. Claimant was considered socially immature and repeated the first grade. His mother reported that his behavior problems were treated harshly and he was terrified in grade school. Claimant advanced quickly in reading but had trouble in math. He was treated with medication trials from age 7 to 11. At age 12 he was evaluated for special education and enrolled in Good Samaritan School, a program of the Good Samaritan Mental Health Center. The parents separated when he was 12. At age 13 claimant received psychological testing at Group Health. Dr. Huffine reported that:

> [claimant] was felt to have under performed on the Wechsler yielding a low average IQ, but some measure of his functioning revealed he had superior capabilities in neuropsychological functioning. He was grossly immature socially.

Claimant moved to California with his mother and was enrolled in a school-based day treatment program, where he exhibited angry outbursts. He accepted the staff structure and "learned fairly well with much support from the teachers and mental health staff." Later when the mother felt threatened by claimant he was returned to his father in Washington.

Dr. Huffine reported his diagnosis as follows:

> [Claimant] more than qualifies for the diagnosis of Asperger's Disorder as follows:
>
> Cluster A – [Claimant] meets criteria for all four (Must have at least two)
>
> 1. Impaired Nonverbal Communication – [Claimant] avoids eye contact unless engaged. He engages in very little social smiling and seems oblivious to the social impact of his gross public tending of his body.

2. Failure to Develop Peer Relationships – [Claimant] has never had an (sic) sustained close friend and most peer relationships are hostile and threatening to him. He has preferred the company of adults or much younger children.

3. Sharing of Enjoyment – [Claimant] prefers to play his games by himself. Shows no sign that he gets pleasure from sharing an activity with another. In sessions in his home he tolerated my looking at him play games, but was too preoccupied with them to share or show me what he was doing.

4. Lack of Social or Emotional Reciprocity – [Claimant] offers little in sessions and when he does he tolerates no feedback or modification of his building anger. He does not respond to my gentle sharing of his effect on me when he has been abusive. This appears to characterize most of his social behavior.

Cluster B – [Claimant] meets criteria for two (Must have at least one)

1. Preoccupation with stereotyped or restricted interests - [Claimant] demonstrates unusual preoccupations with the details of rock music and bands beyond what is typical for his age mates. He has a consuming naïve way of engrossing himself in video games unusual even for teenagers prone to such interests.

2. Stereotyped and repetitive motor mannerisms – [Claimant] has by history been prone to rocking and other self soothing behaviors.

Criteria C – [Claimant's] difficulties cause him clinically significant impairments in family, social and educational functioning. It is reasonably certain that these impairments will impair his ability to find competitive employment.

Criteria D – [Claimant's] language development was described as normal and his reading abilities above average from early in grade school.

Criteria E – [Claimant] has suffered no clinically significant delays in cognitive development, self help skills or adaptive behaviors other then (sic) those involving social interactions.

> He has shown signs of curiosity about his environment throughout his childhood.
>
> Criteria F – He does not meet criteria for any other specific Pervasive Developmental Disorder.

Dr. Huffine concluded his report with a full diagnostic profile for claimant including, on Axis I, "299.80 Asperger's Disorder."

At hearing Dr. Huffine testified that by the time of his January 17, 1998 report he was seeing claimant in claimant's home because he had engaged in a physical altercation with his father at the office, disrupting nearby offices, and had a practice of spitting on the floor when angry.

11. Claimant's initial application for SSI benefits was apparently denied and on June 8, 1988, Dr. Huffine again sent his January 17, report, and in a separate report, stated that:

> The condition affecting [claimant], Asperger's Disorder, is relatively static and as such could not be expected to change in the past six months. …
> [Claimant] remains incapacitated by his condition…. He breaks things often in his father's house. He remains prone to periodic rages in which he makes threats to bodily harm his father, myself or others. His grooming and appearance remain bizarre and he is hostile to attempts to get him to change.

12. On November 15, 1999, Dr. Huffine wrote to the Lake Forest Municipal Court urging that all charges against claimant be dropped. After hearing that his case worker would be leaving, claimant became upset and threatening and engaged in a physical confrontation with his father. Dr. Huffine reported to the court that he had worked with claimant for 3½ years, and had diagnosed him as having Asperger's Syndrome. Dr. Huffine continued to treat claimant for a year after the incident. Claimant repeatedly characterized the altercation as an attempt by his father to get rid of him, to send him to jail, etc.

13. On October 8, 2000, Dr. Huffine wrote a two-page report of his observations, analysis and diagnoses to Catherine Dunn, M.D., a psychiatrist with the Community Psychiatric Clinic (CPC) in Seattle where claimant had received care since mid-1999. Claimant was 21 years of age, and Dr. Huffine reported that he had been working with him since age 17 and had tapered to monthly individual sessions. Claimant was then taking Depakote 500 mg. and Paxil 20 mg. Dr. Huffine wrote:

> Given his poor use of time with me I have long considered dropping my efforts to work with him psychotherapeutically. However I feel I have not integrated my continuing a minimal

> treatment relationship with him into a treatment plan coordinated with CPC which entail (sic) him being more actively involved with your agency over time. I have urged [claimant] to make more use of CPC's services, particularly vocational rehabilitation services and, perhaps, some socialization opportunities. His relationship with his father seems to have stabilized and housing services seem less urgent, but I have urged him to pursue a long term (sic) strategy for semi independent (sic) living eventually. Recently I had arranged for medication services to be taken over by CPC and I am delighted that you have begun working with [claimant] on that aspect of his care. [Claimant] has a terror of being abandoned and despite his scathing diatribes against me at times, it is clear that I am inordinately important to him and that abandonment by me would be experienced badly by this young man. He, on the other hand, wants total control over our relationship including an ability to fire me. We are now in a situation where I see him once a month and if he chooses to cancel my visit shortly after I arrive [at his home], I can do so. If he is abusive or dismissive when I arrive at his house I can leave early or he can throw me out. This arrangement has been initiated in the past few months and seems to be much more satisfactory. I am able to push [claimant] a bit on using CPC better and he seems to relate more comfortably to me. I am content to stay in my minimal supportive psychotherapy role with him and continue to function as an advocate and advisor to him and his father. I have not continued my monthly dialogue with [claimant's] mother for over a year.
>
> Thank you and CPC for taking on this troubled young man. I am glad that you were able to see him and I hope that you can provide consultation to his treatment team as they are clearly frustrated with his failures to follow through and progress.

At hearing Dr. Huffine contended that his letter was also a diagnosis of depression, but acknowledged that neither that diagnosis nor any other specific diagnosis appears in the letter. He then claimed that when many youths with pervasive developmental disorders have an awareness of how different they are from others depression is common, and that "it's a judgment call if depression is significant enough to have a diagnosis of its own." Irregardless of his present view of his letter, he never wrote that claimant was depressed or even suggested that diagnosis in the document.

Finally, Dr. Huffine attempted to "bootstrap" a diagnosis of depression into the letter by testifying that claimant had had a series of medications for treatment of anxiety. Anxiety is a wholly different diagnosis, and his efforts to claim mentioning medications without a

diagnosis or reference to depression were not persuasive. Dr. Huffine acknowledged that he diagnosed Asperger's Disorder, and that the medications were used to control claimant's aggressive behaviors and for mood stabilizers.

14. At hearing Dr. Huffine claimed to reevaluate his long-standing diagnosis of Asperger's Syndrome, and testified that he now would consider that claimant should have been diagnosed as autistic. His testimony and attempt to repudiate his prior reports was not persuasive. He testified to several efforts to tailor reports so that patients could obtain specific benefits. He clearly was flattered by Dr. Grandison's consultation, and influenced by her views.

Moreover, Dr. Huffine testified that he used information from the father (with whom claimant was living) in his reports over the five years of treatment, and that the mother now contradicts that information. His testimony established that he now credits the mother's statements, but he did not consider that she is motivated to obtain services for claimant and, most importantly, that she was less able to report events because she only saw her son on occasional visits.

Notably, Dr. Huffine testified that although he diagnosed claimant with Asperger's Disorder for five years and as recently as October 2000, he now believes that claimant has autism based on Dr. Grandison's information on language delays. He then testified that the "difference between autism and Asperger's Disorder is clinically irrelevant." That statement may describe his current clinical practices; for purposes of the subject proceeding it is incorrect.

15. Claimant's mother testified that he was born three weeks early, and that during her pregnancy she suffered a blow to the abdomen. As an infant and toddler he attended the in-home childcare of Betty Esmay which served her sons and other toddlers. Claimant's mother offered hearsay statements of Ms. Esmay that claimant was quiet, kept to himself, and was not interested when she tried to get him to join in activities. At some unspecified time the mother called a child development hotline regarding her concern that claimant not very expressive or affectionate, and was told that kids develop at various rates and referred to the book "The Magical Child." It made her more concerned because claimant was not soothed by physical contact, did not reach for her, and used few verbal responses. She testified that he did not utilize objects in a playful way but manipulated them with his hands, such as stacking blocks. From 18 months upward he drummed on a ball with sticks, but was unhappy in loud environments. When taken to the park at age two he did not go up to other children, but seemed to like the swings.

From age three claimant attended a Montessori School. He was not toilet trained until age four, and had bedwetting episodes even in his teenage years. The mother offered hearsay that the school expressed concern that claimant did not engage with others, did not follow instructions, and had trouble expressing what was going on with him. He attended the Montessori School for 1½ years, and participated in painting or other activities. At home he

often filled page after page with crayon lines, and his parents used that activity to keep him quiet when he had to wait somewhere like a doctor's office.

In 1984-85 claimant attended Learning Way, a private kindergarten, because his parents heard it was good, and considered that with an August birthday claimant was not ready for public school. The mother offered hearsay that the school reported he did not work well independently, did not follow instructions, did not engage with others, and had self control issues. However, the school reported that he did play well with others. His academic strength was reading, and had no difficulty with written work, but had difficulty with math. The mother was told that perhaps he was very bright and was getting bored, too young for school, or had some learning issues. The mother completed law school in 1984 and has been employed as a lawyer since that time; she paid child support when claimant lived with his father.

At age six claimant went to Highland Park, the neighborhood school, for first grade and was quickly a focus of concern. The Seattle Public School Assessment Report and Summary dated April 17 and June 27, 1986, noted that his teacher thought claimant was inattentive, noncompliant, and had delayed fine motor skills. He was getting into trouble with others by reacting strongly to teasing. He had more problems on the 40-minute bus ride after school to daycare, which he attended because both parents were working. Interventions like a star for sitting quietly on the bus were tried, but he was eventually suspended from the bus on March 7, 1986, following short suspensions and home communication. After the bus suspension his school behavior noticeably improved, and his parents sought the help of a counselor. The WISC-R, Woodcock-Johnson, and other tests were administered; he scored high average generally with verbal concepts a strength area and perceptual organization comparatively weaker. He was observed to have difficulty attending with poor impulse control. The school recommended a less pressured environment in a second year of kindergarten at Schmitz Part, where he would not have a 40-minute bus ride and would have lessened demands upon writing skills with opportunities to perfect other less-taxing fine motor skills. At Schmitz Park claimant made progress in peer relationships.

The next year, 1987-88, claimant attended Schmitz Park for second grade. The October 28, 1987, Assessment Report and Summary included the statement of his teacher that he was a diligent and neat worker, although he became frustrated when asked to correct errors in his work and upset when classmates invaded "his" space. His behavior and attention to task had improved, which his parents attributed to medication for ADD. Because he had just recovered from pneumonia and displayed a negative attitude during testing his results were considered to be minimum estimates of his true abilities. His current WISC-R scores were Verbal IQ of 96, Performance IQ of 90, and Full Scale IQ of 92, placing him in the average range of intelligence. Academically he demonstrated a considerable strength in reading skills, scoring grade 4.9 equivalent on the Woodcock0Johnson test. His word identification was at the beginning sixth grade level, but his decoding skills were not at a level commensurate with his sight vocabulary. His general comprehension was strong, at the high fourth grade level, and on the math cluster he had strengths in numeration, fractions and geometry but weakness in basic operations such as addition and in word problems. The

mother rated him as adequate in all domains on the Vineland Adaptive Behavior Skills measure, but she noted significant areas of concern in areas of eating and sleeping disturbance which may have been related to medication. On the basis of ADD claimant was eligible for special education, and the IEP group recommended that he use the resource personnel at Schmitz Park to assist in math and areas of social interactions and self-esteem while remaining in the general second grade classroom. At the end of the year the resource teacher wrote to the parents that claimant had made considerable progress in math, reading and spelling, and his attitude was more positive. She noted that his complaining and immaturity had improved, and peers were responding to him in more positive ways since his behavior had improved. She noted however that he would need more help with his temper, and that he made hurtful comments to other students and also kicked and hit them. The mother testified she was surprised to receive the letter because she thought his behavior had improved so much.

In 1988-89 claimant was again at Schmitz Park in a regular classroom for third grade. The mother testified that there was some kind of social skill program for reinforcement in which they had claimant play a game with a kid, because there was still concern about his social skills and interaction problems. Claimant had the 150 minutes weekly of the resource room for support to the regular program in math and behavior, and was in the regular classroom 1500 minutes per week. The mother recalled that he tried an instrument but did not do well, and was not selected for the end-of-year performance. He did not have any friends, and was stuck in a locker either trying to avoid students or was placed there by others.

In the 1989-90 school year claimant attended fourth grade at Schmitz Park in a regular classroom with the assistance of the resource room. The mother tried to orchestrate social events for him because his teacher suggested trying to get claimant to interrelate with other children, but there was no reciprocity from the other children. Claimant went to a couple parties, went but not excited and did not report games, etc., to his parents.

Before the 1990-91 school year the parents moved to a suburb, and claimant attended Silver Lake Elementary School for fifth grade. The parents provided information about the Seattle School District's IEP, and another IEP process was initiated during the school year. The mother testified that positive reinforcement was the theme of the day, and they discussed with teacher using it in the classroom. The principal and school psychologist believed an IEP was needed after claimant got very poor scores in math, and resource help was provided. Claimant expressed more reluctance to go to school, and there more reports of his inappropriate reactions in the classroom. After an "F" in math the teacher reported claimant huddled in a ball under his desk and was very non-responsive for the rest of the day. Early in the IEP process at the Seattle School District claimant had been diagnosed with ADD. He took Ritalin, which initially made him more attentive in the classroom, and later Dexedrine. The mother testified that over time Ritalin was not the magic pill, and the perception problems, inability to articulate, difficulty with math, and socialization problems continued.

The mother reported that thereafter claimant was placed in a special education classroom, and the focus became more about his social issues. She recalled that every week it seemed the school was presenting a crisis and various strategies were being suggested including physical restraints. He missed some school because of the death of his maternal grandfather, and the mother described that he "freaked out" when he learned of the cremation because he expected to have to watch him burn. Although the mother notified the school that claimant was dealing with the death of his grandfather he was suspended when he acted out. Claimant was home schooled for a few months by a tutor employed by the school district.

The parents separated in 1991. In the spring of 1992 when he was 12 years old claimant attended Good Samaritan School, an adolescent day treatment program of the Good Samaritan Mental Health Center. In 1992-93 claimant completed seventh grade at Good Samaritan School. He was suspended for pushing a teacher, and again for aggressive behavior toward a teacher. On March 21, 1993, Good Samaritan reported that the preceding month had been the most difficult period for claimant which was attributed to the stress from resuming weekly visits with his father. The intensity of his statements, such as "I'll kill you, etc." were considered to reflect his high level of fear about the world around him. The school's psychiatrist suggested neurological testing, and contact was made with claimant's psychiatrist for that purpose.

In 1993 claimant and his mother moved to Campbell, California, where he attended the Eastfield Ming Quong day treatment program. The mother testified that in California claimant was around his cousins, in contrast to his lack of friends in Seattle. A September 2, 1993 Eligibility Summary noted his qualification for special education as Seriously Emotional Disturbed; no checks were included in the Mental Retardation or Autistic sections. On September 14, 1993, the Wechsler Intelligence Scale and other tests were administered to determine his need for continuing special education services. The report stated that he scored within the average range on the verbal and performance areas and had strong information skills with some deficits in arithmetic and coding. He was found eligible for special education and various recommendations were listed. The mother testified all the recommended had been in earlier IEPs and were unsuccessful in alleviating claimant's problems. The mother recalled that claimant was overreacting in all kinds of social settings, misreading and misperceiving, acting out inappropriately and could not fully express needs, etc. His counselor at Eastfield Ming Quong reported that claimant walked away or withdrew when a request was made; left class or failed to participate, misperceiving things staff were trying to do; and did not engage with others in class or counseling settings. At the end of that year the Campbell Middle School District recommended advancing him to high school.

Claimant attended Westmont High School in Campbell in the regular education program. The mother recalled that from the beginning he was buried in homework and was lost in how to do the assignments. His social studies group received Fs for not working with claimant, who was not interacting with the students appropriately to get the work done. He was not performing appropriately in science and was given a home teacher, which he resisted. His first semester grades were Ds and Fs. Claimant was acting out a lot a home. He did not complete the school year because he moved back to Seattle in March 1995.

In May 1995 claimant attended Shorecrest High School, a continuation school in Seattle. The school psychologist reported that claimant had difficulty with social situations at school in and outside of class. His most recent reassessment continued his eligibility for special education on the basis of Serious Emotional Disturbance, and he received resource room assistance with regular education mainstreaming.

In the 1995-96 school year at Shorecrest High School, the school psychologist reported that claimant entered the testing situation cursing and threatening to kill another student. However, he put forth good effort in the testing until frustrated by math. His test results indicated significantly above average performance in reading, give years above grade level, and math scores were unobtainable because he refused to test. During the interview he expressed that people were out to get him, and he persevered in his verbalizations of fear. By that date he had been in special programs since elementary school on the diagnosis of Seriously Behaviorally Disabled, but current medical reports indicated the diagnosis of Asperger's Disorder. During the year his teachers reported failure to complete assignments, failing tests, and absenteeism. The December 9, 1996, IEP noted he was a teacher assistant in the Essential English class and demonstrated compassion for the needs of students and willingly helped them and clarified instructions. Claimant was found to need instruction for organizational skills and task completion.

The September 19, 1997 IEP noted claimant's need for a highly structured supportive educational environment. At school his behavior escalated rapidly early in the year, and he started skipping classes and having outbursts including storming out of classrooms and physically accosting other students. Claimant verbally threatened campus security, administration and staff, and had to be physically restrained on two occasions. He was transferred him to the Phoenix Program, a special education program for students with behavioral problems, to address his academic, social and behavioral deficits. On October 28, 1997, the father received a Notice of Action that claimant had demonstrated increased aggressive behavior with verbal threats and assaultive behavior, and he would be changed to an individualized schedule.

In the 1998-99 school year claimant continued to attend Shorecrest High School at age 19. He was in the general education program, with pull-out special education classes for academic and emotional support. His Woodcock-Johnson test results indicated good skills in reading, written language and passage comprehension. He graduated from Shorecrest in June 1999, and a few years later attended some community college courses in Seattle.

16. The mother testified that before treatment with Dr. Huffine claimant saw counselors in family and individual sessions at various ages starting at age six, but it was of no effect because he continued to have the same problems. He has never had any gainful employment, and moved back with her because he had come to the end of what the Seattle service system had to offer and could not get community housing.

Since claimant moved back with his mother in November 2004 he has had no gainful employment or job training. The mother helped him with an application at the Department of Rehabilitation, attended an orientation, and they both met several times with his case worker, Nancy Morgan, to discuss getting him employment. Ms. Morgan initially thought he could attend a workshop in Sunnyvale, but noted a better baseline situational assessment was needed, and there is a long wait for that service. They discussed that supported employment through Community Options is not available to him because he is not a regional center client.

The mother testified that she applied for SARC services to obtain supportive employment for claimant, with the expectation that claimant could eventually contribute to his support and move out of her home. She told claimant that SARC would be able to provide services to achieve his goal of independent living, employment, and better functioning in the world and "he was all for that." The record does not disclose why she promised that he would receive SARC services before an eligibility determination was made.

The mother testified that claimant can dress himself, showers every other day, can mop floors and wash dishes, has a bank account, can use an ATM, can use a computer including transferring music to his iPod, can use a microwave, etc. She stated that he lacks basic living skills, cannot count change, cannot read a bank statement or verify a bank balance on-line.

Claimant pays the mother a monthly sum for rent and food because he does not like to go to the grocery store, and has been confrontational with a shopper whose cart bumped him. He spends the couple hundred dollars from his monthly SSI check however he wishes. The mother believes he has been taken advantage of at used game stores, but has been unsuccessful in teaching him to research the value of used games online. Although she claimed he had no friends, she testified that people who claim to be his friends have taken his games or money. She is concerned about his ability to get around in the world in terms of safety; he uses public transit but needs a lot of help figuring out how to get to a certain place.

17. Karen Mercer is the Director of the Independent Living Skills Program at Community Options, an agency which provides services to adults with developmental disabilities. Some services are provided to individuals who have been found eligible for SARC services, and are paid for by SARC. Ms. Mercer has 18 years' experience in the ILS program, which is affiliated with five apartment complexes for people with special needs. Commencing in April 2006 Community Options performed a privately-paid assessment of claimant using the Public TRACE assessment tool, which allows up to 20 hours to go through various tasks. The Community Options report, which was completed by others but reviewed by Ms. Mercer during editing, was dated August 2006. If SARC eligibility could be obtained her agency could be paid to provide ILS services to claimant.

The Community Options report noted that claimant's wanted to learn skills in money management, job applications, new bus routes, first aid, personal and social safety, household chores, scheduling, and cooking. He likes music, technology and video games

and would like to work in a music or video game store. The report stated that he "was diagnosed with Autism;" the basis for that statement was not identified.

In the course of the Community Options assessment claimant found the right section in Safeway and purchased food, and recognized that he had enough money although he could not calculate the change. He correctly prepared the fish filets in the oven, served them with lemon and tartar sauce, and cleaned up. He could count paper money and coins with 100% proficiency, read price tags, and count money to match. He could not calculate change in his head. He uses his ATM card to get cash. The mother reported that he spends money within the first two days of the month, and claimant concurred that he does not save and makes impulse purchases, primarily music or computer items. He agreed that he would be unable to prioritize his spending and would probably avoid paying bills. He could read sample bills, write a sample check, and correctly place both in an envelope.

Claimant currently takes to bus or is driven by his mother. He recognized many traffic and safety signs, but was a little unfamiliar with those pertaining to driving. He was good at obeying street crossing signs but was unsafe walking into the street when cars and the Light Rail were approaching. Claimant has a cell phone but relies on his mother to schedule appointments; the evaluator believed he could master that skill. The evaluator opined that claimant is a "fairly responsible young man" who could be doing more for himself if properly instructed, and that he has decent decision-making skills other than his tendency to impulse buying. The evaluator concluded that with proper help, such as ILS services, he could live on his own within a year or two.

Ms. Mercer testified that claimant has needs similar to those of people referred to Community Options by SARC, such as individuals with seizure disorders, Downs Syndrome, cerebral palsy, etc. Ms. Mercer did not demonstrate familiarity with the particulars of eligibility for SARC services.

Ms. Hayes-Luong, who used to work at Community Options, considered its August 2006 report to reflect that claimant was doing well in his adaptive abilities. The noted behaviors and skills were consistent with her observations of claimant, and the responses he provided when asked what he would do in given situations.

18. The DSM-IV-TR identifies the diagnostic categories for mental disorders. The DSM-IV-TR section titled "Pervasive Developmental Disorders" describes that "Pervasive Developmental Disorders are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communications skills, or the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctively deviant relative to the individual's development level or mental age." The "Pervasive Developmental Disorders" identified in the DSM-IV-TR are Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS). The distinction between disorders is significant because only Autism, also termed Autistic Disorder, is an eligible condition for regional center services under the Lanterman Act.

19. Autistic Disorder is characterized by impairments in social interaction, communication and imaginative play before three years of age, featuring stereotyped behaviors and restricted interests and activities. The DSM-IV-TR section 299.00 states

> DIAGNOSTIC FEATURES:
>
> The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and markedly restricted repertoire of activity and interests. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual. Autistic Disorder is sometimes referred to as early infantile autism, childhood autism, or Kanner's autism.
> The impairment in reciprocal social interaction is gross and sustained. . . .
> The impairment in communication is also marked and sustained and affects both verbal and nonverbal skills. . . .
> Individuals with Autistic Disorder have restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. There may be an encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus (Criterion A3a); an apparently inflexible adherence to specific nonfunctional routines or rituals (Criterion A3b); stereotyped and repetitive motor mannerisms (Criterion A3c); or a persistent preoccupation with parts of objects (Criterion A3d). Individuals with Autistic Disorder display a markedly restricted range of interests and are often preoccupied with one narrow interest (e.g., dates, phone numbers, radio station call letters.) They may line up an exact number of play things in the same manner over and over again or repetitively mimic the actions of a television actor. They may insist on sameness and show resistance to or distress over trivial changes (e.g., a younger child may have a catastrophic reaction to a minor change in the environment such as rearrangement of the furniture or use of a new set of utensils at the dinner table). There is often an interest in nonfunctional routines or rituals or an unreasonable insistence on following routines (e.g., taking exactly the same route to school every day). Stereotyped body movements include the hands (clapping, finger flicking) or the whole body (rocking dipping, and swaying). . . .

DSM-IV-TR section 299.00 further states under the heading "DIFFERENTIAL DIAGNOSIS" that "Periods of developmental regression may be observed in normal development, but these are neither as severe nor as prolonged as in Autistic Disorder. Autistic Disorder must be differentiated from other pervasive Developmental Disorders."

The diagnostic criteria for Autistic Disorder are listed in DSM-IV-TR section 299.00. The diagnosis requires at least two qualitative impairments in social interaction; at least one qualitative impairment in communication; and at least one restricted repetitive and stereotyped pattern of behavior, interest, or activity. The section states:

> DIAGNOSTIC CRITERIA FOR 299.00 AUTISTIC DISORDER
>
> A. A total of six (or more) items from (1), (2) and (3), with at least two from (1), and one each from (2) and (3):
>
> > (1) qualitative impairment in social interaction, as manifested by at least two of the following:
> > (a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
> > (b) failure to develop peer relationships appropriate to developmental level
> > (c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
> > (d) lack of social or emotional reciprocity
> >
> > (2) qualitative impairments in communication as manifested by at least one of the following:
> > (a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime)
> > (b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
> > (c) stereotyped and repetitive use of language or idiosyncratic language
> > (d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
> >
> > (3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
(b) apparently inflexible adherence to specific, nonfunctional routines or rituals.
(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
(d) persistent preoccupation with parts of objects.

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in communication, or (3) symbolic or imaginative play.

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

20. Asperger's Disorder is characterized by impairments in social interaction and by the presence of restricted interests and activities, but with no clinically significant delay in language and with intelligence testing in the average to above average range. The neurobiological disorder is named for Viennese physician Hans Asperger, who in 1944 published a paper describing a pattern of behaviors in several young boys of normal intelligence and language development who exhibited autistic-like behaviors and marked deficiencies in social and communication skills. It was not until 1994 when Asperger's Disorder was added to the DSM-IV that the disorder became generally recognized by professionals and the public.

The DSM-IV-TR criteria for Asperger's Disorder are:

A. Qualitative impairment in social interaction, as manifested by at least two of the following:
(1) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
(2) failure to develop peer relationships appropriate to developmental level
(3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
(4) lack of social or emotional reciprocity

B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal in either intensity or focus
(2) apparently inflexible adherence to specific nonfunctional routines or rituals
(3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole-body movement)
(4) persistent preoccupation with parts of objects

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

D. There is no clinically significant delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).

E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.

F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

21. Pervasive Developmental Disorder – Not Otherwise Specified Including Atypical Autism (PDD-NOS) at DSM-IV-TR section 299.80 is a diagnosis used when a child does not meet the criteria for a specific diagnosis. The introduction to the DSM-IV-TR describes that "The Not Otherwise Specified categories are provided to cover the not infrequent presentations that are at the boundary of specific categorical definitions." Section 299.80 provides that the PDD-NOS category should be used:

> . . . when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or non-verbal communication skills or with the presence of stereotyped behavior, interests, and activities, but the criteria are not met for Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder.

22. The "Fifth Category" under Welfare and Institutions Code section 4512, subdivision (a), requires the presence of a condition that is closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals. As with the four other developmental disabilities identified in section 4512, subdivision (a), a Fifth Category disability must have an onset before age 18 and must constitute a substantial handicap.

The DSM-IV-TR describes mental retardation as significantly subaverage intellectual functioning (an IQ score of 70 or below) accompanied by significant limitations in adaptive functioning in two or more of the following areas: self-care, home living, work, leisure, health, social/interpersonal skills, safety, use of community resources, self-direction, and functional academic skills. An IQ measurement error of approximately five points permits an individual with an IQ between 70 and 75 to be diagnosed with mental retardation if that individual exhibits significant deficits in adaptive behavior.

23. Both Autism and Asperger's Disorder are characterized by some identical symptoms and overlapping diagnostic criteria. Asperger's Disorder requires a determination that the disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning. Asperger's Disorder is distinguished by no clinically significant delay in language, no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than social interaction), and curiosity about the environment in childhood, and that criteria are not met for another specific Pervasive Developmental Disorder. In short, the diagnosis of Asperger's Disorder means that the clinician has ruled out other PDDs including Autism.

Here, claimant was never diagnosed with autism until age 26 despite years of scrutiny in the school districts, clinics, and treatment by Dr. Huffine, although it is a disorder that must manifest itself by age 3. As an adolescent and adult he had been diagnosed with other conditions, including Asperger's Disorder. Claimant did not have delay in developing spoken language, and the reports of Dr. Huffine (as contrasted with his efforts to repudiate his statements) establish that he could sustain conversations and use language for self-expression. Similarly, claimant's conversations with Dr. Heimlich and Ms. Hayes-Luong, and his clear recognition of the consequences of denial of eligibility and verbal responses to that subject, establish his ability to initiate and sustain conversations. Dr. Grandison's report and testimony established that she attempted to modify the DSM-IV-TR criterion by introducing additional factors of the social aspects of communication.

Dr. Heimlich noted a consideration that was key in this dispute: that for reliability it is important to obtain information/reports as close in time as possible to the events being described, and from a variety of people. She considered that Dr. Huffine showed great thought in his reports in considering information and a handful of diagnoses applied to claimant in the past, and that in formulating the diagnosis of Asperger's Disorder he ruled out other diagnoses including autism and continued to use the diagnosis over time as he continued treatment. Dr. Heimlich considered that if Dr. Huffine found his diagnosis inadequate during the following years of treatment he would have done so. She noted that Dr. Huffine also found claimant to be a very emotionally disturbed person.

Dr. Heimlich's conclusion that claimant has Asperger's Disorder and not autism was persuasive. The historical reports demonstrate factors inconsistent with autism, including timely meeting developmental milestones, early IQ test results, kindergarten and first grade reports that he played with others, and reports of caring response to peers as a teacher's

assistant. His difficulties with anger management, emotional disturbance, and depression are mental health concerns but not evidence of a developmental disability.

Although Claimant has symptoms consistent with Autism and with other disorders, he has many characteristics that make him quite unlike an autistic individual, including verbal aggression, seeking attention from others, caring for others as reflected in his performance as a teacher's assistant in reading, and that his verbal IQ is much higher than his performance IQ. SARC established that in terms of a diagnosis on the pervasive developmental disorder spectrum, Asperger's Disorder is the disorder that Claimant most closely meets. Dr. Grandison acknowledged that claimant's deficits in social interaction, restricted and repetitive behavior and interests are consistent with Asperger's. Her consideration of claimant's social problems made no distinction between autism and Asperger's Disorder, attempted to ignore the separation between those diagnoses established by the DSM-IV-TR. The more persuasive evidence was the series of reports by Dr. Huffine, who diagnosed claimant with Asperger's Disorder by November 1996 on the basis of information from both parents and the schools.

24. Claimant also asserts eligibility under the "fifth category" as a person having a condition that requires treatment similar to that provided to the mentally retarded. Cal. Welf. & Instit. Code § 4512(a); 17 Cal. Code of Regs. § 54000(a). To so qualify, however, the disabling condition may not be a learning disability, a psychiatric problem, or something physical in nature. 17 Cal. Code of Regs. § 54000(c).

Here, the evidence did not establish that claimant's condition currently or before age 18 demonstrated significantly sub-average intellectual functioning or concurrent deficits or impairments in adaptive functioning. In consequence, he does not have either of those characteristics at levels like those found in individuals with mental retardation. In marked contrast to the qualifying criteria, claimant's cognitive function as measured by IQ testing throughout his schooling was so far above the range of mental retardation such that he cannot be said to be mentally retarded or having a condition closely related to mental retardation. Even the recent neurological testing by Dr. Ulray did not reflect such conditions, but rather mental inflexibility and difficulty with some problem solving.

That claimant might benefit from services such as those funded by SARC, including specifically the programs offered at Community Options, does not establish that he meets the "fifth category" of eligibility.

25. The mother testified that she expected SARC to investigate claimant's case more. SARC received and considered documents and evaluations completed during claimant's schooling, including psychological assessments and test results, and the numerous and lengthy reports of Dr. Huffine. The evidence considered was consistent, and the reports of Dr. Huffine covered more than five years of consistent psychiatric treatment and repeatedly diagnosed Asperger's Disorder. The mother did not submit or identify any documents that SARC did not consider. The view that SARC had an obligation to seek out any other information is not persuasive.

LEGAL CONCLUSIONS

1. Claimant did not establish by a preponderance of evidence that he meets the criteria for a diagnosis of Autistic Disorder under the DSM-IV-TR .

2. Claimant did not establish by a preponderance of evidence that he meets the criteria for eligibility on the basis of a disabling condition closely related to mental retardation or requiring treatment similar to that required for people with mental retardation.

ORDER

Client's appeal of service agency's decision to deny services is DENIED.

NOTICE

This is the final administrative decision in this matter and both parties are bound by its contents. Either party may appeal this decision to a court of competent jurisdiction within ninety days.

Dated: _____

_____
M. AMANDA BEHE
Administrative Law Judge
Office of Administrative Hearings